UNITED CONCORDIA
America's Premier Dental Insurer

SOG5000D

State of Georgia Dental Dependent Enrollment Form

Regular and PPO Options

Thank you for selecting United Concordia dental coverage. We look forward to servicing your dental needs. **If you elected family coverage**, we ask that you please complete the below information. Please return this form to us in the enclosed postage paid envelope within five business days. If not received in a timely manner, the dental benefits for your dependents may be delayed. If there are any questions regarding this form or your State of Georgia dental benefits please contact us at (866) 215-2356. Please note that this form is available for online submission at *www.ucci.com/was/ucciweb/clients/georgia.jsp*.

EMPLOYEE INFORMATION:

Employee Last Name: _____ Employee First Name: _____ Middle Initial: ____
Employee Date of Birth: _____ Contract ID (such as SSN): __ __ __ - __ __ - __ __ __ __ Employee Gender (M/F): ____

Home Address: _____ City: _____ State: _____ Zip Code: _____
_____

DEPENDENT INFORMATION

Dependent ID (such as SSN)	Type	Last Name	First Name	Middle Initial	Gender (M/F)	Date of Birth
__ __ __ - __ __ - __ __ __ __	Spouse					
__ __ __ - __ __ - __ __ __ __	Dependent (a)					
__ __ __ - __ __ - __ __ __ __	Dependent (b)					
__ __ __ - __ __ - __ __ __ __	Dependent (c)					
__ __ __ - __ __ - __ __ __ __	Dependent (d)					
__ __ __ - __ __ - __ __ __ __	Dependent (e)					

Please list data for additional dependents on another page and submit.

I represent that all information supplied is true and correct. Any person knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

Employee Signature _____ **Date** _____

All statements made by a policyholder or by any insured member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the policyholder.

Note to Florida residents: Any person who knowingly, and with intent to injure, defraud, or deceive, any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Underwritten by United Concordia Insurance Company